Thank you, Mr. Chairman, and Members of the Committee for allowing me to address continued whistleblower retaliation within VA. My involvement with whistleblower retaliation dates to November, 2011, when my colleague, Dr. Michelle Washington, testified before the Senate Veterans Affairs Committee on the lack of access to mental health treatment. Not only was Dr. Washington retaliated against before and after her testimony, but other professional colleagues closely associated with her and with our professional union, AFGE Local 342, were retaliated against, as well. Methods of retaliation included denial of administrative leave, unsatisfactory performance rating, exclusion from department communications, removal of professional duties, enhanced scrutiny of clinical record charting, investigation by the OIG, and being the subject of a formal Administrative Investigation Board (AIB).

Since then, others who have spoken out against management practices or managers who have spoken in favor of their subordinates have been retaliated against, removed from their regular duties, or have left VA under pressure or unwillingly. In September, 2014, AFGE Local 342 members announced a no-confidence vote over management's sudden downgrading of surgical services and further reduction in clinical offerings, such as inpatient bed availability. Subsequent retaliation against AFGE Local 342 members included non-consideration for internal position vacancies, an extraordinary increase in workload, a noticeable reduction in workload, inaccurate labor mapping, loss of electroencephalography services for Veterans at the facility, and a number of staffing adjustments.

The following professionals remain detailed away from their regular duties to date:

> Associate Chief Nurse (almost one year), Nurse Manager (almost one year), Registered Nurse (~seven months), Nurse Manager (~six months), Nurse Manager (~two months), Radiologist (~five months), Otorhinolaryngologist (~five months), Ophthalmologist (~one month), Quality Manager (~two months), Nurse Executive (~six months), and Senior Project Engineer (almost three years).

None were involved in scheduling, though all are involved in access to care. Many of the individuals made disclosures to senior management and would be considered whistleblowers if the information had been reported outside VA. Several AIBs have been convened reportedly examining different areas of practice, such as surgery services, pathology services, long-term care, inpatient care services, and non-VA care services. Two individuals reportedly had no alleged misconduct confirmed after investigations were completed, yet the individuals remain on detail. Almost all were not told the scope of any investigation or any reason for an investigation. None were given any forewarning of any concerns regarding their performance.

The disruptions from these personnel moves continue to have a very negative effect on staff. A GAO report on "VA Administrative Investigations" (GAO-12-483) found it critical for AIBs to be convened and conducted appropriately, as well as for information to be shared about improvements implemented in response to the results of AIB investigations. Compliance appears lacking in the aforementioned instances. Since the personnel moves do not appear to have been made to correct behavior or to have been made for the efficiency of public service,

they appear to be a waste of medical talent and a waste of VA funding. Plans to realign VA services by addressing or right-sizing legacy programs, transitioning from a hospital bed-based system of care to an ambulatory/primary care model, and shifting resources from low-volume programs to other programs already were announced in 2011. There should be no underlying fear of discussing and planning for staffing adjustments driving these personnel moves. With no overt valid cause for their occurrence, constitutional rights appear maligned.

Psychological safety in a work setting has been defined as the extent to which employees feel able to ask questions or bring up team issues without being afraid of hurting their reputation, status or career. In a psychologically safe environment, employees have a shared belief that it is safe to take interpersonal risks, such as asking for help, admitting a mistake, questioning a procedure, or pointing out a mistake, and view these actions as "worth the trouble." (*Adapted from Edmondson, A.C. [1999] Psychological safety and learning behavior in work teams. Administrative Science Quarterly, 44,*350-383)

Workplace violence as defined by VA is any physical assault, threatening behavior, or verbal abuse that occurs while working or on duty. Lateral violence includes bullying, scapegoating, smearing someone's reputation, refusal to help, exclusionary behavior, intimidation, or other incivility. (*Veterans Health Administration Workforce Succession Strategic Plan 2011*) Bullying includes these behaviors familiar to VA employees: establishing impossible deadlines that will set up the individual to fail, undermining or deliberately impeding a person's work, removing areas of responsibilities without cause, constantly changing work guidelines, withholding necessary information or purposefully giving the wrong information, assigning unreasonable duties or workload which are unfavorable to one person, under work or creating a feeling of uselessness, unwarranted or undeserved punishment, and excluding or isolating someone socially.

Data from the Stress and Aggression study (VISNs 23 and 11) indicate that the predominant trigger of aggressive behavior in staff is related to frustrating systems and processes, while the main triggers of aggressive behavior in patients are frustrating interactions with staff and the ensuing sense of powerlessness. Enabling people to relate to one another with confidence and trust, and to root out suspicion and mistrust, is a way to strengthen democratic spirit and a sense of community. When officials and employees forget they are rendering a public service and behave in a manner to suit their own convenience rather than that of the public they are supposed to serve, a social institution can lose its humanity. (Jaques, Elliott [1976] *General Theory of Bureaucracy*) When money and resources available to government are diverted from the benefit of citizens, the seeds of conflict are sown.

Corruption, as defined by the *United States Institute of Peace*, is the abuse of entrusted power for private gain. Corruption creates a system whereby money and connection determines who has access to public services and who receives favorable treatment. (*Governance, Corruption, and Conflict)* Corruption undermines the trust and shared values that make a society work. Howard Wolpe, scholar and former US Representative, called corruption a symptom of divided societies, where success (or survival) comes at the expense of others. "To the extent that you can begin to alter that paradigm – to generate interdependence, and to recognize that

collaboration can strengthen one's own self-interest, you begin to impact the drivers of corruption."

The story of VA is a story of two different organizations; there is the VA that takes care of Veterans, and there is the VA that takes care of itself. If VA is pictured as a diamond, Veterans are at one tip of the diamond, while the VA Secretary is at the other tip of the diamond. Between the Secretary and the Veteran is what whistleblowers perceive to be ever expanding layers of management consuming the majority of funds earmarked for their task, and creating an increasingly challenging system denying them success in providing good care.

Whistleblowers tend to be those closest to Veterans in the diamond model. Whistleblowers tend to report on the VA-for-VA system when it appears to be operating at the expense of the VA-for-Veterans system. Concerns arise with regularity at the start of each fiscal year when medical center directors announce a 'zero budget increase' for operations. A knee-jerk response leads to consolidation of functions and hiring freezes. Salary dollars of professional staff typically are identified as the largest line item in the budget requiring trimming. New strategic goals and increased overhead costs also are givens. Since Veterans Equitable Resource Allocation (VERA) is driven by provider encounters and reportedly accounts for 75% of medical center budget allocations, flat-line budgets typically lead to the cutting of clinical personnel that further drop future VERA reimbursement and cause more cuts to staffing in the long-run.

Along with ever-escalating demands to meet performance measures, unclear role relationships and inadequate channels of authority lead to constant personal manipulation at all levels. Licensed professionals subject to §7422 of Title 38 are constrained further by the Secretary's control over clinical practice and competence, leading to their experiencing additional inequalities and abuses. Reports to OIG, OMI, OSC, EEO, or JCAHO more often than not are sent for investigation to the very same VA reported for not following its own rules and regulations. This is in sharp contrast to The Washington Post report earlier this year on an Atlanta jury convicting 11 teachers of racketeering and other crimes in a standardized test-cheating scandal by teachers and administrators who felt under pressure to meet certain score goals at the risk of sanction if they failed. Why is VA not held to the same standard of correction?

Respectfully,

Maryann Hooker, MD
President
AFGE Local 342

"If men were angels, no government would be necessary. If angels were to govern men, neither external nor internal controls on government would be necessary. In framing a government which is to be administered by men over men, the great difficulty lies in this: you must first enable the government to control the governed; and in the next place, oblige it to control itself."
James Madison